



State of New Jersey
Commission of Investigation

SCENES FROM **AN EPIDEMIC**

**A Report on the SCI's
Investigation of
Prescription Pill and Heroin Abuse**

July 2013

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July 2013

Governor Christopher J. Christie

The President and Members of the Senate

The Speaker and Members of the General Assembly

The State Commission of Investigation, pursuant to N.J.S.A 52:9M, herewith submits its final report of findings and recommendations stemming from an investigation into prescription pill and heroin abuse in New Jersey.

Respectfully,

A stylized, cursive signature of Patrick E. Hobbs.

Patrick E. Hobbs
Chair

A cursive signature of Robert J. Martin.

Robert J. Martin
Commissioner

A cursive signature of Joseph F. Scancarella.

Joseph F. Scancarella
Commissioner

A cursive signature of Eric S. Pennington.

Eric S. Pennington
Commissioner

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Executive Summary

Stopping regularly in downtown Newark, the nondescript minivans drew a select clientele: homeless Medicaid recipients and drug addicts who had been told by flyers and word-of-mouth where to wait for a ride. Ten miles and 15 minutes later, they arrived at a strip mall “medical center” on Main Avenue in neighboring Passaic where a doctor licensed by the State of New Jersey quickly got down to the business of cursory examinations and bogus diagnoses. Then he wrote prescriptions for powerful painkillers, sedatives and cough syrup, which his “patients” could use themselves or sell on the street, their choice. They also left with \$10 cash gift cards as thanks for coming in. The bill for it all went to government health insurance, which funneled a fortune in fraudulent Medicaid reimbursements into the bank accounts of the hidden entrepreneurs the doctor fronted for – associates of Russian organized crime.

The flagrant and unbridled operation of this pill mill and others like it, the descent of sworn medical professionals into outright drug dealers, the intrusion of organized crime and other criminal elements into lucrative recesses of the health-care industry to feed an epidemic of demand for drugs: These are among the key findings of the State Commission of Investigation’s ongoing probe of illegal trafficking in and abuse of prescription painkillers and other addictive narcotics.

Even as law enforcement authorities, public-health officials, social workers, treatment counselors, schools and families redouble their efforts to combat the purveyors and consequences of this predatory scourge, it continues to evolve in ways that few could have imagined when the so-called war on drugs was launched more than four decades ago.

Staggering amounts of legitimate medicines manufactured by major pharmaceutical companies and intended for those needing relief from the pain of disease and injury have been diverted into criminal enterprises founded on drug abuse and addiction. What once was a menacing background narrative centered narrowly around subculture-based substances like opium, morphine and heroin has exploded into a mainstream horror story whose first chapter often begins with pill bottles in the average household medicine cabinet. Some medical management companies with names that incorporate benign terms like “pain management” and “wellness” have transformed street-corner drug-dealing into an orderly and seemingly ordinary business endeavor, except for the hidden financial backing from individuals linked to organized crime, the multiple bank accounts for money-laundering, the expert help of corrupt physicians and the shady characters who recruit and deliver customers and provide security.

Meanwhile, conventional drug dealers – those tied to criminal street gangs and similar criminal enterprises – exploit legitimate businesses like used car dealerships, clothing outlets, barber shops, bars and liquor stores to cover their illicit retail commerce. They take advantage of advanced computers, communications and social networking technologies to facilitate criminal activities and thwart law enforcement. And they are finding new ways to profit from a market hungry for addictive drugs stretching well beyond New Jersey’s cities and into the outlying affluence of its suburbs and rural communities.

On the demand side, witnesses told the Commission during an unprecedented public hearing that, given the shared properties of pain-numbing, high-inducing substances known as opiates and opioids, the widening abuse of prescription pills containing Oxycodone and related chemical ingredients has triggered a new and sustained rise in use of the original opiate of

choice – heroin. Indeed, with high-quality heroin readily available on New Jersey streets today at roughly the same price as a pack of cigarettes – cheaper than painkilling pills of similar strength and effect – it should be no great surprise that the road to addiction has evolved full-circle. And all too often ensnared in this harrowing, potentially lethal cycle – in many instances before they, or their families, even know it or suspect it – are adolescents, teenagers and twenty-somethings, young people on their way to becoming a new lost generation of what used to be called junkies.

Also, much of what used to take place “underground” in the drug milieu is now happening in plain sight. With the advent of instantaneous communication technology and suburban demand, a handful of pills or a bag of heroin is only a text message or cell-phone call away as many dealers now deliver product to customers waiting in shopping-mall parking lots. Former suburban high school students told the Commission that the depth of their prescription pill and heroin dependency played out in full view of teachers and other adults who they said did not seem to have a clue or even care when they nodded off and fell asleep in class, day after day. During a three-week surveillance operation at several major intersections in downtown Trenton, Commission investigators observed a bustling open-air drug market daily during morning rush hour within blocks of New Jersey’s Statehouse.

Law enforcement authorities are quite familiar with the spiking collateral damage from this disturbing trend: the thefts and violence, the burglaries, armed robberies, pharmacy hold-ups and worse. Elsewhere on the frontlines, drug treatment facilities are seeing record numbers of admissions for heroin and other opiate/opioid addictions.

The Commission undertook this inquiry pursuant to its unique statutory responsibilities to examine public corruption and abuse, to ascertain whether adequate laws and regulations are being faithfully executed and effectively enforced and to inform the Governor, the Legislature, the Attorney General and the public at-large of the activities of organized crime in all of its facets. The public-awareness component is particularly vital in the context of this investigation because of the nexus between the criminal underworld and matters that bear directly upon the health, safety and welfare of every man, woman and child in New Jersey.

Government agencies already have taken the initiative to boost public education as an integral part of the effort to curtail pain pill diversion. The New Jersey Division of Consumer Affairs (DCA) employs a range of strategies to inform the public about proper use and handling of pain medications. The State's "Project Medicine Drop" enables consumers to dispose of unused or expired medications anonymously at secure drop-off boxes located at numerous local police departments. Moreover, the perils of non-medical use of pain medication were brought to light in a recent public service campaign, "The Right Prescription for New Jersey," in which the SCI, along with the U.S. Drug Enforcement Agency (DEA), the Partnership for a Drug-Free New Jersey and other entities, produced multi-media advertisements, including a radio message from a New Jersey woman who lost her son to a prescription-pill overdose.

More significantly, from an operational standpoint, DCA administers New Jersey's year-old Prescription Monitoring Program (PMP), part of a nationwide effort to track and control the volume of prescription-dispensed drugs subject to abuse, including controlled dangerous substances and human growth hormone. DCA's statewide PMP database gathers information from pharmacies about the prescriptions they fill, prescribing physicians, patients and the

names, strengths and quantities of the medication dispensed. Pharmacies that fail to report are subject to fines and other disciplinary action by the New Jersey Board of Pharmacy. DCA administrators, licensed practitioners and law enforcement authorities are permitted to access the database under limited circumstances.

Still, the findings of this investigation demonstrate that the challenges posed by drug abuse have taken on disturbing dimensions that call into question the conventional wisdom regarding gateway drugs and addiction, as well as the adequacy of current oversight and enforcement strategies. We now live in a state where abuse of prescription pills serves increasingly as a primary route to the unlawful world of heroin, an intersection of the legitimate and the illicit that constitutes a crisis whose devastating consequences are plain for all to see. To address this crisis, the public discussion about establishing a sensible drug policy needs to be broadened and amplified. While considerable debate has attended such matters as legalizing marijuana for medical purposes, the ease of access to other drugs that already are legal – drugs that are highly addictive, potentially lethal and very much like heroin – raises far more complex and troubling issues.

Thus, building upon actions already taken by and beyond the realm of government, the Commission offers a comprehensive set of statutory and regulatory reforms. Those responsible for policing physicians, pharmacists and others in the medical community should re-examine and strengthen oversight and disciplinary mechanisms to ensure appropriate professional standards and accountability. Individuals and entities that operate businesses associated with or profiting from medical practices should be subject to more intense scrutiny to identify intrusion by elements of organized crime. The Prescription Monitoring Program should be

strengthened, and law enforcement should have greater access to data and information collected through it in order to target illicit prescribers more effectively. Tougher criminal penalties should be imposed for possession with intent to distribute heroin, and certain essential tools of the drug trade, including throwaway cell phones and hidden storage compartments in motor vehicles, should be more closely regulated. In sum, these and other measures set forth in greater detail at the conclusion of this report would establish potent disincentives against illicit pill diversion and heroin trafficking, while simultaneously providing regulators and law enforcement authorities with better weaponry and information to root out violators.

The Russian Connection

Health-care fraud has long been a signature money-maker for criminal groups emanating from Eastern Europe and the former Soviet Union. Distinguished from traditional organized crime by the absence of highly structured and centralized hierarchies, these groups nonetheless engage in widespread criminal activity, generally operating through disparate cells that band together around crimes of opportunity, including a variety of schemes to loot government health insurance funds through bogus injury and other false medical claims. During this investigation, the Commission found that members and associates of Russian organized crime established seemingly legitimate medical treatment centers in New Jersey fronted by corrupt physicians who combine Medicaid fraud with an increasingly lucrative adjunct – the illicit distribution and diversion of addictive prescription drugs. One such enterprising professional is Dr. Joseph W. Dituro, who, licensed to practice medicine in New Jersey in 1983, sold out his oath to a succession of mobbed-up medical management companies that netted a combined sum of more than \$1.4 million in government health insurance payments.

Dituro began his career as an emergency room doctor in New Jersey after completing medical school in Guadalajara, Mexico. In the late 80s, he relocated to New Mexico as a regional medical director of that state's prison system and later served as medical director of an inpatient treatment facility for addictive disorders at a New Mexico state psychiatric hospital. He then moved to Los Angeles, opening a vitamin and holistic health store that ultimately went out of business, a circumstance that led to his return to New Jersey.

In early 2009, responding to a classified ad on the internet website Craigslist for a “medical director,” Dituro was hired to fill that position at Passaic Medical Center, a small private office located in a strip mall at 831 Main Avenue in Passaic. The facility was owned at the time by Passaic Medical Management Co., whose principal – Michael “Michail” Lipkin – was a longtime Russian organized crime operative linked to a variety of criminal fraud schemes. The SCI reported on some of Lipkin’s criminal ties in the early 1990s during a period in which, among other things, he was the target of an attempted mob hit in New York City. As Lipkin’s employee, Dituro was responsible for examining patients at the medical center for a weekly salary of \$4,000. Aside from the organized crime element, this arrangement was contrary to state law.

Dituro was employed in a manner that violated regulations set forth by the New Jersey State Board of Medical Examiners. Those regulations require licensed physicians to practice within the scope of a narrow set of Board-sanctioned professional settings. For example, a medical licensee is permitted to serve as a solo practitioner. He/she may also practice in a partnership, professional association or limited liability company but only if such an entity is comprised of licensed health-care professionals. Passaic and other medical management companies that subsequently employed Dituro were owned by unlicensed individuals, such as Lipkin, and, thus, failed to meet the Board’s requirements. Although the regulations do allow a licensed doctor to be employed by a professional practice that contracts with a general business entity, such as a medical management company, to provide non-professional services such as routine office management, hiring of clerical and other non-professional staff, provision of office space and/or equipment and servicing, and billing services, there were no such

agreements between Lipkin, Dituro and Passaic Medical Management or any subsequent medical management company that employed Dituro.

Furthermore, Commission investigators found that Dituro and Lipkin took steps to cloak their business relationship in a guise of legitimacy for the purpose of bilking government health insurance programs. Since Lipkin was not a licensed medical practitioner and Passaic Medical was not a sanctioned professional association, neither could lawfully collect monetary reimbursements through Medicare and/or Medicaid. To circumvent that prohibition, Dituro opened an account in his own name at Valley National Bank to serve as a depository for the receipt and disbursal of government medical payments.

Dituro told the Commission in sworn testimony that Lipkin pressured him to see as many government-insured patients as possible. In fact, he stated that Lipkin would complain if he (Dituro) failed to prescribe pills to any patient who asked for them. Dituro said the office recruited business by relying on “word-of-mouth advertising” among government health insurance recipients at area shelters for the poor and homeless. Medical center employees, he stated, were paid to transport willing individuals to the medical center in vans from various shelter facilities in Newark, including Urban Renewal Corp. at 224 Sussex Avenue, various Salvation Army facilities, the YMCA at 600 Broad Street and St. John’s Soup Kitchen at 23 Mulberry Street. On busy days, he typically saw 20 to 25 patients who were subjected to examinations lasting about 15 minutes each. In some cases, Dituro stated, patients departed with prescriptions without even seeing a doctor. He said he observed instances in which another licensed physician at the center would remain in his office while a nurse performed the

examinations. One patient who visited with Dituro described a typical encounter with the doctor as follows:

It's really no examination. The nurse basically knows all about you before the doctor, so she's giving him the paperwork and he's going by what you need at the time. So he's just making sure you get your medicine, that's it. He is really just signing his signature and keeping it going. It's really nothing to him. He really is full of crap, really.

Virtually every individual who visited Passaic Medical was insured by Medicaid or Medicare, and the office regularly billed those programs for services whether rendered or not. Upon receipt of payment from the government, Dituro commonly wrote checks from his professional bank account to Lipkin for or near the exact amounts of the insurance reimbursements. According to Dituro, these transactions occurred simultaneously. On many occasions, he would deposit checks from Medicaid and/or Medicare and, while still at the bank, immediately draft checks to Lipkin or to Vadim Khorutsky, a Lipkin lieutenant, for deposit in the management company's account.¹ Dituro told the Commission he transferred nearly all of the money that flowed into his account from government insurance funds – more than \$750,000 – to Lipkin's management company over the course of seven months.

This business relationship dissolved in August 2010 when Lipkin moved his operations to a larger facility on Branford Place in downtown Newark. For his part, Dituro approached the owner of a dental lab he knew in nearby Wallington and proposed the establishment of a practice similar to Passaic Medical. That individual was Lev Natovich, a Russian organized crime associate and convicted felon. Natovich's mob involvement dated back more than a decade

¹ Analysis of the Passaic Medical Management Center LLC account with Valley National Bank disclosed that checks totaling \$752,216 were issued directly to the Center.

when he enlisted the help of his uncle, Leonid Abelis, in an attempt to intimidate a witness before a grand jury gathering evidence in a health-care fraud investigation aimed at Natovich and his late father, Boris Natovich.² Abelis was a top lieutenant to Vyacheslav Ivankov, identified by law enforcement at the time as the most powerful leader of the Russian Mafia in the United States.³

In response to Dituro's proposal, Natovich established Wallington Wellness Management Co. in September 2010, incorporating it in the name of his mother because she possessed a stronger credit rating. Approximately one month later, Dituro was hired by the new entity as a physician. The Natoviches initially located the office in the same building as their dental lab in Wallington but soon moved it to Passaic because of zoning problems. For Dituro, it was almost like homecoming: The newly leased site was on the same premises vacated by Lipkin. Based upon sworn testimony from Dituro and others, it is evident as well that Wallington's owners ran their medical center in the same manner as Passaic Medical Management – with a few operational improvements. In addition to generating word-of-mouth buzz among poor and homeless government insurance recipients in Newark area

² In July 2003, Boris and Lev Natovich, along with Dr. Joseph Matriss, were indicted by a state grand jury on charges of conspiracy, health-care claims fraud and theft by deception. The indictment charged that, between 1999 and 2002, the Natoviches and Matriss operated United Dental Center in Wallington, N.J. Without any formal training or the requisite licenses, Lev Natovich and another employee performed various dental procedures on at least 33 patients, five of them children, and submitted fraudulent bills to insurance companies seeking payment for these unlicensed medical procedures. Matriss was a New Jersey-licensed dentist who allowed his name and identification number to be used on all insurance claims submitted by United Dental Center. His case was referred to the State Board of Medical Examiners. In July 2005, Lev Natovich pled guilty to submitting fraudulent reimbursement claims. He was sentenced to six months in drug rehabilitation, ordered to pay \$12,000 restitution and placed on probation for five years. In 2009, he was charged a second time with practicing dentistry without a license. He pled guilty, was fined \$2,155 and again placed on five years' probation.

³ Ivankov was shot as he left a Moscow restaurant in July 2009 and died of his injuries two months later. Authorities found a sniper rifle abandoned in a car parked nearby and believe he was gunned down on orders of rival mobsters.

shelters, Wallington not only directly employed staff to transport patients but also maintained a stable of freelance drivers to shuttle van loads back and forth.

A patient told the Commission that many people recruited and transported to Wallington Wellness were not sick or in need of medical treatment but rather were willing to be “examined” in exchange for the opportunity to earn quick cash reselling the unnecessary medication prescribed by Dituro. The patients also said the doctor took precautionary steps to ameliorate the risk that those who entered the office would blow the whistle on what went on there. For example, he would only dispense prescriptions to patients who had gained his trust over the course of at least three prior visits. Moreover, Dituro did not bill Medicaid and Medicare solely for the cost of examinations and treatment. He also required each patient to receive immunization injections, undergo an electrocardiogram and have two Magnetic Resonance Imaging (MRI) tests on file irrespective of any ailment or diagnosis – all billable to government health insurance programs. Beyond that, according to a patient, Dituro and the Natoviches boosted their profits by double-booking people for phantom appointments, enabling them to collect duplicate government reimbursements for only a single patient visit.

This lucrative flow of cash, however, carried a perilous downside for those profiting from it, and by May 2011 Wallington Wellness was experiencing serious problems. A victim of its own success, the location began to draw inordinate attention, overrun by people looking for pain pills. Would-be patients in search of scripts often arrived drunk or high, and drug paraphernalia, including crack-cocaine vials and hypodermic needles, regularly turned up in the center’s restrooms. In an effort to enforce control, Natovich hired a bouncer. Shortly thereafter, this individual was himself discovered using heroin on-site and fired. These

circumstances finally prompted Natovich to close the center and terminate his involvement in May 2011 by selling the business and equipment for \$150,000 to another associate of Russian organized crime, Oleg Gorodetsky.⁴

Remaining at the same location in Passaic, Dituro was employed by Gorodetsky's firm, Broadway Medical Management, for several months in 2011, receiving a salary boost to \$6,000 per week. Consistent with the methodology of his precursors, Gorodetsky profited by using the doctor as a front in the provision of unnecessary medical procedures and pain medication to government-insured patients. This arrangement, however, was short-lived. According to Dituro, it ended after Gorodetsky physically attacked him.

• • •

The Commission examined the full scope of Dituro's personal and professional records and found that, over time, the various money-making schemes he helped orchestrate were quite profitable for his organized-crime-connected employers. In 2010 and 2011, Dituro received periodic payments totaling more than \$1,663,000 for services purportedly rendered to patients covered by Medicaid and Medicare in New Jersey. During that same two-year period, the doctor dispersed \$1,434,000 in payouts to Lipkin, Natovich and Gorodetsky through their medical management companies – Passaic, Wallington and Broadway.

With regard to the diversion of addictive pain medicine, the Commission found that Dituro prescribed significantly larger amounts of such drugs than his peers. During the 19-month period from January 2010 through September 2011, he wrote more than 2,600

⁴ Natovich told the Commission in sworn testimony that Gorodetsky, whose criminal record includes an arrest in New Jersey on charges of using runners to recruit chiropractic patients, ripped him off in the Wallington deal by refusing to pay more than \$30,000 for the company.

prescriptions – an average of nearly 137 a month, or 34 per week – that were filled through Medicaid. The vast majority of those, 90 percent (2,434) were for Endocet, a pain-killing medication that combines Oxycodone and Acetaminophen, and other pain medications, including OxyContin and Roxicet. Records show that in 2011 alone, Dituro ranked third among all physicians in New Jersey in the number of Schedule II (narcotics) drug claims he submitted to Medicaid.⁵

Cities to Suburbs, Pills to Heroin

He wasn't poor, and he didn't live in the city. In fact, by all outward appearances, at least to the untrained eye, Jake S. looked like a normal suburban high school student, hanging out with friends and popular in social circles that extended well beyond his 10th-grade class.⁶ But there was a special reason for his wide popularity, and it had nothing to do with good looks, athletic prowess, academic skill or just being cool.

At the tender age of 16, Jake was the biggest narcotics distributor in his neighborhood, and most of his customers were his schoolmates.

He started experimenting with prescription pills when he was “around 11 or 12 and progressed from there,” he told the Commission. By 14, he was hooked, variously and in combination, on Valium, Percocet, OxyContin, Xanax and Fentanyl – whatever would give him that “high.” It got to be an expensive habit, and that's when he started dealing, moving

⁵ Between January 2010 and September 2011, records show that Dituro submitted 2,686 Schedule II claims to Medicaid. For this time period, he submitted the third highest level of such claims of all physicians in New Jersey.

⁶ Not his real name. His identity is protected because he served as a confidential source during the Commission's inquiry. He provided sworn testimony via disguised video and audio during the Commission's June 2011 public hearing.

hundreds of pills a week – sometimes as many as 500 – at upwards of \$25 apiece with bulk discounts for youthful buyers who purchased in volume. “It was to the point where I would never have enough,” Jake said. “I would never have enough for myself, and I would never have enough for everybody else”

But the pills kept coming, thanks to the ease with which he could purloin and manipulate prescriptions. In some cases, people he knew with legitimate health issues would obtain scripts from their doctors for Percocet, OxyContin and other painkillers, fill them and then, to make money, sell the pills to him for cash. In others, they would visit a local version of Dr. Dituro. “People would go to crooked doctors . . . [who] would take extra money on a visit – charge people \$75 a visit,” he said. “You would go to them, you would tell them what you want and they would just write the script. People that didn’t have insurance . . . would let me know that they got the script . . . and I would pick them up . . . and we would go to the pharmacy and I would give them money to fill [it] . . . [W]e would wait there, and I would get the pills.

“As many scripts as I [could] get is how much I would sell in a week. . . . I would sell them to high school students, I would sell them to adults, but the big crowd was just the high school students.”

Now 22, Jake was among a number of Commission witnesses who described desperation on the demand side of a national prescription-pill epidemic that has found victims in virtually every corner of New Jersey. In stark terms, they also described how abuse of legal painkilling medication has triggered a resurgence in the abuse by young people of the illegal analogue of those substances – heroin – which generally costs less, delivers a stronger high and, these days, is more readily available than ever in areas with suburban and rural zip codes.

One measure of the scope of this crisis is the startling rise in the rates of patient admissions to drug addiction treatment centers. The number of individuals who entered such facilities in New Jersey for opioid pill addictions tripled from 2006 to 2011, with more than 8,600 admissions in 2011 alone. Of those patients, nearly half were age 25 or younger. Over that same period, heroin addiction admissions to New Jersey treatment facilities jumped by nearly one-third for those under age 25, with more than 6,600 during 2011 alone.

Some addicts and dealers are employing aggressive means to obtain pills illicitly, as evidenced by the increasing number of pharmacy robberies. According to the U.S. Drug Enforcement Agency (DEA), armed robberies of pharmacies jumped by more than 80 percent nationwide between 2006 and 2010. Circumstances in New Jersey are emblematic of that trend. DEA reports that from 2006 until April 2011, there were 58 reported pharmacy robberies here resulting in the theft of nearly 56,000 units of Oxycodone. In one instance, a pharmacist at Brunswick Pharmacy in Trenton was shot and killed in April 2011 during a botched robbery attempt. In 2010, the same pharmacy was robbed by a masked gunman who stole more than \$10,000 worth of prescription pills.

Meanwhile, the proliferation of heroin has required law enforcement to devote increasing resources on that end of the epidemic. Late last year, the DEA, in conjunction with the New York Drug Enforcement Task Force and the New Jersey State Police seized more than 16 pounds of heroin during the search of a house in an upscale neighborhood of Cliffside Park, Bergen County. This suburban home served as a heroin production facility; enough heroin was found there to fill at least 600,000 individual doses with a street value estimated at close to \$6 million. Also, during a 10-month investigation that began in 2012, law enforcement officials in

rural Hunterdon County arrested 47 people for possession and/or distribution of heroin. Information gathered during the course of that investigation led to the interception in Flemington of a \$1.25 million heroin shipment from Honduras that was smuggled into the U.S. via Kennedy International Airport in New York.

Authorities say no community, however affluent or remote, is immune to the circumstances and impact of this trend.

“It’s everywhere,” Detective Sergeant Brian Jernick of the Vernon Township Police Department in Sussex County, New Jersey’s rural northwestern corner, told the Commission. During a four-year period, nine recent high school graduates died from painkiller and/or heroin overdoses in Vernon, a community with a population of less than 30,000. Jernick, who works with juveniles and who personally responded to some of those calls, noted that several of the victims had taken a combination of the two substances. Meanwhile, at the other end of the State, in the small Camden County community of Gloucester City, five funerals were held over the span of six weeks in 2011 – all for individuals in their 20s and 30s, all victims of what police described as a bad batch of heroin.

Data provided by the Office of the State Medical Examiner, show 843 drug-related deaths occurred in New Jersey in 2010. Of those, 402 were attributed solely to prescription drugs, 261 to illicit drugs and 180 to some combination of prescription and illicit drugs. Those numbers, however, do not fully reflect the role played by prescription drugs because many victims were using more than one substance at the time their deaths. According to Dr. Roger Mitchell, the Assistant State Medical Examiner, prescription drugs were present in some form in nearly three-quarters of the cases recorded that year. Moreover, the official cause of death in

the majority of these instances was “mixed drug toxicity,” meaning a lethal combination of drugs. Oxycodone was found to be present in 244 of these cases while another 287 involved heroin/morphine.

In 2011, the latest year for which such data is available, drug-related deaths statewide jumped to 1,008 – an increase of nearly 20 percent. Again, nearly three-quarters involved prescription drugs. Of those, 337 were mixed-drug deaths involving Oxycodone – a 38 percent increase over the prior year – and 368 were mixed-drug deaths involving heroin and other illicit drugs – a 28 percent increase over 2010. Additional analysis by the Medical Examiner’s Office showed that persons under age 25 accounted for 14 percent of the Oxycodone-related deaths. Of those, nearly half died from a combination of heroin and Oxycodone. It is also noteworthy, given past social stereotyping of drug abuse, that nearly 90 percent of the Oxycodone-related deaths in 2011 involved individuals classified by race as “white.”

Beyond the devastation of lost lives, law enforcement authorities at multiple levels told the Commission that the drug trade and the resulting imperative of addiction have produced spikes in burglaries and other crimes of theft all across New Jersey. Detective Sergeant James Scoppa, an investigator for the Atlantic County Prosecutor’s Office, testified that his region has experienced an unusually high rash of crimes involving thefts of copper pipes and wiring stripped from homes and businesses and sold for cash. In more than a decade in law enforcement, Scoppa said he has never seen any drug that can grip users the way heroin does. He estimated that at least 50,000 small glassine packets of heroin flow into Atlantic County every week, retailing for between \$5 and \$10 apiece on the street, compared to as much as \$80 per pill for the strongest dosage of the painkiller Oxycodone. “Every day that a heroin addict

wakes up, all he cares about is getting his heroin high and nothing else in the world matters,” Scoppa testified. “They’ll steal from their own family members . . . from their own grandfather. They’ll go burglarize a home, they’ll go rob a bank, they’ll rob a pharmacy to steal prescription pills so they can get their high.”

Law enforcement officials throughout the State repeatedly described the same rising cycle of theft: stealing and selling family jewelry or other valuables, then stealing from friends and neighbors, then breaking into the homes of strangers. Although conventional wisdom dictates that residential burglaries typically occur on weekdays when people are away at work, police in numerous communities have seen a telling shift: break-ins by young inexperienced addicts who are committing these crimes in broad daylight on weekends without using gloves or any other tool to cover their intrusion. One detective recounted an interview with a young heroin addict arrested for his role in more than 70 burglaries. This abuser had developed a 10-bag-a-day heroin habit after abusing pain medication. He admitted to committing weekend burglaries in the desperate, if irrational, hope that someone would “catch him and kill him.”

• • •

Mary P. knows all about the descent into thievery, and into heroin.⁷ Like Jake a suburban New Jersey high school student when she hit the depth of her addiction, Mary started with prescription pills when she “was maybe ten or 11.” Over time, when people she knew were no longer so accommodating or generous with their pill stash, she wound up scrounging money to support a habit that eventually took her into class high just about every day of the

⁷ Not her real name. Her identity is protected because she served as a confidential source during the Commission’s inquiry. She provided sworn testimony via disguised video and audio during the Commission’s June 2011 public hearing.

school year once she reached 10th grade. By her own description, she would be “nodding out” and looking “ghostly and pale” but no adult ever approached her about it. The teachers, she said, “didn’t seem like they ever caught on” or they seemed “to look past it.” To feed the addiction, she told the Commission, “I would steal from friends, family, anyone who was around. . . . I had a job, but I would also steal from the job.”

One day when she was 15 or 16, she was introduced to snorting powdered heroin by some “friends,” a circumstance that softened the gutter-junkie stigma associated with that drug. She said she came to prefer it over pills “because you needed less of it to get higher, and it was less expensive as well,” at least at first: two bags of heroin a day for \$15 versus nearly \$100 for pills of similar effect. Within a year, though, her addiction blooming, she was spending a comparable amount on heroin – and injecting it intravenously. Initially hesitant about using a needle, a “friend asked me if [I] wanted her to do it for me, and . . . I just went for it, and I liked the feeling, so I continued to do it.”

Jake, too, eventually found himself cornered by the insidious economic and narcotic efficiencies of heroin once his dependence on painkillers began to exceed the limits of their effectiveness. “I was able to make more money by doing heroin because my pill addiction was just through the roof at that point,” he testified. “I actually snorted heroin probably when I was 13 . . . but it didn’t really do that much to me just because I was high on Xanax or pills [W]hen I started picking it up [again] around 14, it progressed quick – really quick. I mean, it took probably six months . . . until I started shooting it – six months to a year at most. And then, once I started shooting it, there was no going back to snorting it.”

At the deepest point of his addiction, Jake estimated he was using five “bricks” of heroin – 50 stamp-sized packets, also known as a “bundle” – every day. And since he had already established himself as a “go-to” guy for drugs, he took a bunch of other kids with him once he made the jump. “A lot of people that bought pills off me, sad to say, . . . switched to heroin around the same time I did.”

When he testified before the Commission in June 2011, Jake had found a way to push back against pills and heroin. He had been “clean” for months. But little more than a year later, he was arrested and charged with stealing thousands of dollars worth of jewelry and other valuables. When the police picked him up with an accomplice, he was found to be in possession of marijuana, heroin and a hypodermic needle.

‘They Want It, We Got It’

If the criminal street organization known as the Bloods had a slogan to reflect the growth and geographic expansion of its customer base in recent years, the above would be a suitable candidate. It came from the mouth of a Trenton-based Bloods leader who was explaining the core aspect of the gang’s burgeoning suburban market for heroin and other drugs. He told the Commission in sworn testimony that demand for heroin in outlying communities is such that some elements of the Bloods have set up processing and packaging outposts away from city streets where the raw material, arriving in compressed, rock hard, egg-shaped chunks, is placed in the hands of a specialist known as a “whip-up man” who breaks it down with high-speed commercial blenders and other tools. To increase volume – and

profitability – it is then mixed with other powered substances that sometimes include ground-up prescription painkillers, a technique known as “cutting” and “stretching.”

“They know how to stretch it,” he said. “If you don’t know how . . . your game [is] in the gutter.”

Gang operatives, he stated, have also taken to using taxi cabs and other forms of public transportation as a safe and reliable means of covering the movement of their product out to the point of sale. “[In] a cab . . . we can put it underneath the back seat . . . ,” he said. If stopped and arrested, “[we can] say, ‘How many people [ride] this cab?’ . . . [A] million people could have been in and out of there. . . . You can’t say I did it, unless you follow me from my spot, but we constantly keep changing spots up.” Rental cars are popular as well because they can be easily secured in the name of “clean” straw renters who are hidden gang associates, they can be switched periodically and, if seized by police, they do not carry the risk of a costly forfeiture action because the gang does not own them.

Law enforcement officials around the State confirmed the changing dynamics and demographics of heroin processing, packaging and sales. “I’d say 90 percent of our deals take place in public areas, shopping malls, right out in public they’ll meet and conduct their transactions,” Lieutenant Thomas Dombrowski of the Bergen County Prosecutor’s Office testified. “Heroin is here, and there is a lot of it.”

Detective Sergeant Barry Graves of the Monmouth County Prosecutor’s Office told the Commission he used to see open-air drug trafficking concentrated in urban zones like sections of Asbury Park, but “due to enforcement and technology, now they are moving out to suburbia . . . [W]e have the Route 66 corridor, which is a link to the [Garden State] Parkway, and . . . they

are just meeting right off 66 and 33 . . . at the [commercial] outlets. . . . [T]hey make a phone call, the dealer comes out to them and make[s] the sale right there. . . . [Y]ou know, get away from going into Asbury Park and the potential of getting robbed or being the target of law enforcement.”

Another drug corridor is Route 23 running southeast from rural Sussex County through the affluent communities of northern Morris County and into Passaic and Essex. A heavily traveled road that has become known as “Heroin Highway,” Route 23 links suburban demand with urban supply emanating primarily in the cities of Paterson and Newark.

When dealers find it necessary to use personal or otherwise privately-owned vehicles to facilitate transactions, they have become adept at secreting drugs, guns and cash onboard inside specially wired, difficult-to-detect chambers known as “traps” or “stash spots.” Access to these hidden compartments, some of which have been found secured by sophisticated piston-driven seals, is restricted to those who know a sequence of triggering actions, such as dialing the radio to a certain frequency in combination with opening a certain window and turning on the parking lights. “They are all over a vehicle,” Lt. Dombroski testified. “You can get them in the front dashboard, you can actually get them installed behind air bags if an air bag is removed. The seats themselves can be utilized. We’ve had them in rear seats, in trunks of vehicles. . . . [I]t’s up to the imagination of the individual who basically builds the trap.” The Trenton Bloods member seconded that observation. “There are so many different methods that the police can’t really, you know, track us down,” he testified. “Only way you can really do it [is] if you strip the car, and you strip it down to the metal, then you got it, but if you just search the car and put a dog in it, you’re not going to find it, so we good.”

Gang-related and other drug dealers also readily exploit innovative communications and computer technology, including cell phones, texting applications, and other mobile devices and techniques, and utilize various social networking mediums like Facebook, MySpace and Twitter to communicate with cohorts and customers. Some in the law enforcement community are concerned that criminal street gang members may even be using live-chat functions available through gaming consoles, such as Xbox and PlayStation because they know such outlets are beyond routine monitoring by the authorities.

Pre-paid cell phones – also known as “throwaways” or “burners” – are the most favored communications tools of the drug trade because they leave no trail back to the user. These units are purchased with air-time already loaded, and there is no subscription requirement for a monthly service plan. Typically, once the minutes expire, the phone is thrown away. Investigators have found that since these relatively inexpensive devices are usually bought with cash and no proof of valid identification is required of the purchaser, it is difficult, if not impossible, to trace a phone to a given individual. Moreover, buyers can select any available area code and phone number.

“You can pretty much make up any identity you want,” Det. Sgt. Graves told the Commission. “[A]fter a certain period of time, you want to change the number, you can. You can get any extension throughout the country. You can put down any address wherever you want.” He described his own experience. “I went in to buy one of [these] phones and the guy said, ‘Well, what name do you want?’ and I was like, ‘What do you mean,’ because I was ready to give him my undercover ID. He said, ‘Well, I’ll give you John Gotti,’ and he gave me John

Gotti's name and made it a New York address and a New York extension and everything else. So that's pretty much how they operate."

Graves, Dombroski and other law enforcement officials told the Commission that the widespread and continuing proliferation of burner phones complicates routine police work and can disrupt and delay narcotics investigations. Among other things, these devices can defeat conventional wiretap surveillance strategies because the phones are discarded so frequently. Also, it is not uncommon for drug dealers to use multiple burners in rotation or for dealers to be found with up to six phones in their possession upon arrest. Another challenge is that many of these devices are designed in such a way as to make the data they contain inaccessible. Even in instances where information related to calls and messaging is retrievable, telecommunications carriers do not maintain uniform data retention policies. In the case of texting, for example, some carriers retain copies of the content of such messages for several days while others keep no record at all. In either event, information that could be valuable to investigators typically is long gone before they can lawfully gain access to it.

Another technique employed by those seeking to avoid detection is to have data removed from a phone by a wireless carrier under the pretext that it was lost or stolen. This option is particularly handy for unscrupulous users of smart phones that incorporate computer features and can hold large amounts of data that could be useful to law enforcement. While it is not uncommon for regular customers to request a remote data "wipe" for privacy and security purposes in the event such devices go missing, authorities told the Commission this is also something suspected criminals, unbeknownst to authorities, can set in motion if their

phones are confiscated. Once the wiping process is underway, it cannot be halted or reversed and, thus, there is no way to recover the data.

As communications technologies evolve, gang-affiliated drug dealers quickly adapt. Recently, law enforcement officers reported that text-messaging has become a favored form of communication for dealers over “push to talk” or “chirp” functions on cell phones, which dominated the scene just a few years ago. According to testimony provided to the Commission in 2011 by a Bloods member, street-level drug retailing at that time was substantially less efficient and more risky without the cell-phone chirp function, which enabled runners and look-outs to signal the presence of police or other threats in an instant. This capability, he said, was critical given the fact that many transactions occur indoors in buildings controlled by the gang. With the advent of texting, the gangs, like the rest of society, have simply upgraded to a higher level of efficiency.

“Police got so much surveillance now . . . we stepped our game up, we in an apartment building,” he said. “You want to come in and get us, by the time the corner watcher . . . hit[s] his [phone], boom, we know to flush it. We don’t really have that much stuff in there – only enough that we know we can move. So, if you hit the door, we flushing it. I take that loss. That ain’t nothing. We going to get it right back.”

The New ‘Drug Corner’

Before his luck ran out, Dr. Michael Lam didn’t have all that much to worry about when it came to possible detection of his drug-dealing venue. Unlike his gangbanger counterparts, he didn’t occupy a known or suspected stash house. Nor did he have to engage in a constant war

of wills with the competition over turf control on one side or another of a given street intersection. He was a licensed physician in a low-key private practice with offices in Fort Lee, so what was there to suspect?

Indeed, for a long time, Lam avoided sending up any number of potential red flags, including dealing with health-insurance carriers. Unlike Passaic Medical Management, Wallington Wellness and other unscrupulous medical practices bent on ripping off Medicaid or committing some other form of fraud, Lam was strictly in the business of orchestrating prescription drug deals. For his regular pill-addicted patients, he didn't go through the motions of conducting any physical examinations. He had no medical equipment. Just a table and a small desk where he sat, writing out Oxycodone scripts for a constant stream of customers willing and able to pay cash.

Lam received his medical degree in 1993 from the Morehouse School of Medicine in Atlanta, Georgia, and interned at Nassau University Medical Center in New York. He was licensed to practice in New York in 1994 and in New Jersey in 1998.

Described by addicts as a “real gem” and a “candy man,” Lam developed a customer base so voluminous that the waiting time in his office could run as long as two and a half hours. New “patients” paid a flat fee of \$260, with the cost of subsequent visits reduced to \$130 plus a \$30 urine test fee.⁸ Those seeking more than one prescription would pay an additional \$130 for each. One former client described Lam as “all about the money. I show him a few hundred, and [the doctor will] give me a few extra prescriptions.”

⁸ The Commission found no evidence that such tests were ever conducted.

A former patient described a typical visit to Lam's office. Upon arriving, the source paid \$130 and received a receipt. The source then saw the doctor and requested prescriptions for Oxycodone. After paying an additional \$260 cash, the source said Lam took the money, put it in his trouser pocket and promptly wrote five scripts – three for Oxycodone 15 mg (70 count) and two for Percocet 10 mg (30 count). Two of the five were dated the day of the visit; the others were dated to reflect other visits weeks in advance. The source then left without any physical examination by the doctor.

Over time, Lam's reputation spread well beyond Bergen County and surrounding communities. Eventually, the suspicions of local law enforcement authorities were aroused when police ran the tags of cars parked in a lot outside Lam's office and found that many were registered to owners in the southern part of the state. Further investigation showed that numerous Oxycodone prescriptions issued with Lam's signature were being filled by South Jersey pharmacies. Lam was arrested in his office on December 21, 2010 by the Fort Lee police working in conjunction with other law enforcement agencies. Executing a search warrant, police found a significant amount of cash, including hundred-dollar bills in his pants pockets and a wooden box containing money in the patient consulting room. A subsequent consensual search of his personal residence in Englewood Cliffs turned up a cash hoard totaling more than \$153,400, three-quarters of which consisted of twenty-dollar bills – the denomination typically found in the possession of common drug dealers. Much of this money was broken down into individual packets concealed in various locations within the residence in what appeared to be an attempt to hide the cash and avoid financial reporting requirements.

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In Atlantic City, Dr. Manuel Nigalan set up shop in similar fashion but with a few refinements. For one thing, he hired a security guard to screen “patients” and serve as an office gatekeeper/bouncer. For another, he was careful to avoid being observed accepting or handling cash.

A graduate of the University of Santo Tomas Faculty of Medicine and Surgery in Manila, the Philippines, Nigalan received his New Jersey medical license in 1974. He was hired by an Atlantic City hospital but subsequently began leading a double professional life. By night, he worked as an emergency room physician; by day, he operated a pill mill out of a private practice in Atlantic City that he took over in 2003. Those worlds collided several years later when addicts who had come to rely on him for drugs began turning up at the hospital during his shift to pester him for medically unnecessary prescriptions. According to a subsequent investigation by the U.S. Drug Enforcement Administration (DEA), Nigalan angrily shooed them away, telling them to contact him only at his private office through an individual identified as Lonnie Sanders, a private security guard he employed to interview and evaluate prospective patients before selling them prescriptions.

In addition to screening office visits, Sanders regularly provided Nigalan with lists of individuals who wanted prescriptions for Oxycodone and other drugs but were not yet coming to see him. Once they were cleared for “treatment,” Nigalan would issue the scripts, which would then be given to the patients by Sanders in exchange for cash.

An undercover Atlantic County Prosecutor’s Office detective working with the DEA on allegations of illicit drug distribution by Nigalan told the Commission that the physician was quite cautious in his dealings with prospective clients. After attempting unsuccessfully on

several occasions to schedule an appointment, the detective learned he could only gain entree if an established patient introduced him to Nigalan's security guard. The detective ultimately gained that introduction through an individual who agreed to act as a confidential law enforcement source. During the meeting, he said, Sanders quizzed him about his relationship with the source and, once satisfied with the explanation, described how the script transaction would work. Sanders told the detective that prior to seeing the doctor, he (the detective) would be required to pay a one-time "finder's fee" of \$300 and an additional "doctor's fee" of \$200 to Sanders in cash. Sanders also instructed the undercover officer on how to complete the patient history form, provided him with purported reasons why he needed to see the doctor and told him to bring an MRI with him on his first visit to the office. Sanders told him it did not have to be his own MRI; if necessary, he said, office personnel would simply change the name on one and place it in the detective's patient file.

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Most days of the week, South Broadway near Mt. Vernon Street in Camden is a desolate patch of nearly deserted sidewalks and shabby buildings, including one that houses Atlas Chiropractic with boarded-up windows and a battered front door. But if it's a Tuesday, and the doctor is in – that would be Dr. Randy Zeid – the intersection comes to life with a sort of street-carnival atmosphere featuring people socializing, cars parked in every direction and a constant stream of foot traffic to and from the Atlas office where Zeid works part-time. Abandoned though it may appear, this structure nonetheless is home to a painkiller-prescription emporium that has resulted in the distribution of hundreds of thousands of addictive pain pills in recent years – including, during one 19-month period alone, a cumulative amount containing the

combined equivalent of nearly 10 kilograms of Oxycodone with a street value estimated at nearly \$10 million.

Zeid received his medical training at the Philadelphia College of Osteopathy, which he completed in 1988. After graduation, he did his residency in Ohio and, in October 1990, became a licensed physician in the State of New Jersey, certified by the Board of Medical Examiners in the area of family medicine. He has been employed by Virtua Hospital as a family physician practicing at Virtua Family Medicine of Browns Mills for the last 20 years. About nine years ago, however, he opened a “pain practice” within the offices of Atlas Chiropractic in Camden to supplement his income.

According to Zeid, he set up shop at Atlas in 2004 at the invitation of the facility’s owner and operator, Dr. Adam Benn, a chiropractor whose limited license precludes him from writing prescriptions. Under the State’s current regulatory framework, a practitioner with a lesser license – e.g. Doctor of Chiropractic – may not employ a licensed medical doctor such as Zeid. Thus, rather than place Zeid on the Atlas payroll, they entered into an arrangement in which Zeid formed a new professional corporation, Strain & Sprain Center PC and agreed to pay a monthly fee, currently \$750, for use of Atlas’ office space. Benn then started referring chiropractic patients seeking pain management and medication to Zeid whose full medical license authorizes him to write and sign prescriptions.

Commission investigators found that during his tenure at Atlas, Zeid has prescribed prodigious amounts of pain medication. The records of one local pharmacy alone show that during a single 19-month period from January 2010 to July 2011, Zeid wrote more than 3,100 prescriptions for Schedule II drugs. Virtually all of the pills – 99.7 percent – contained various

quantities of Oxycodone. Payment for these prescriptions included approximately \$104,000 to the pharmacy in cash and more \$749,000 billed to various insurance companies.

Given the large volume of pain medication prescribed by Zeid, investigators sought to ascertain whether any of the pills found their way into unauthorized hands. Tracing various prescriptions, they discovered links to criminal activity in South Jersey. For example, a police search warrant yielded pills prescribed by Zeid in the possession of someone other than a patient. In another instance, an investigation of several public works employees led to the arrest of one who was found to have distributed pills prescribed by Zeid. Further, while conducting surveillance in an unrelated matter, a Haddon Township detective observed a number of individuals, including known drug abusers, standing in line outside a neglected building in the City of Camden, which he later determined to be the location of Atlas.

The Commission also examined the experiences of several former patients of Zeid and discovered questionable circumstances surrounding their treatment and access to pain medication. One individual, on parole after serving jail time for committing robberies to support a heroin addiction, tested positive for morphine and provided his parole officer with a note from Zeid that stated he was taking pain medication as part of treatment for back pain stemming from a motor vehicle accident. The officer contacted Zeid's office to advise him of the man's heroin issue and to express concern about him being prescribed Oxycodone. According to the officer's reports, the doctor stated that the parolee had been treated for pain for about a year without any problems. The man admitted to the officer, however, that he was struggling with Oxycodone dependency. During a subsequent home visit, the officer observed abundant amounts of medication prescribed by Zeid for the parolee and his live-in girlfriend.

Eventually, this individual sought admission to a drug treatment facility but was expelled less than three weeks later after testing positive for narcotics. At that time, he admitted to crushing and snorting five to six Oxycodone pills per day and stated that Zeid was still prescribing him pain medication.

Another individual who went to Zeid was a former government employee who had lost his job after an arrest and conviction for illegal distribution of Oxycodone. Having shattered his foot in a prior work-related injury, he had received medical treatment from several doctors through Workers' Compensation. During the course of that treatment, he was prescribed opioid pain medication, which ultimately resulted in dependence. He told the Commission that although he still required pain medication (partially for pain and partially for dependency), his primary doctor would no longer prescribe it, so he started "doctor shopping" to find other physicians who might be less restrictive. He said he learned of Zeid through a friend. After visiting Atlas and seeing Benn on five occasions for various chiropractic adjustments, he was referred to Zeid for pain management. After an examination, Zeid prescribed Oxycodone.

Zeid acknowledged that "it gets a little crazy" at Atlas on the days he is present to examine and treat patients at the Atlas facility in Camden. To maintain order, he said, Benn employs security guards. During surveillances conducted at that location when Zeid was working, Commission investigators witnessed the following suspicious activity:

- A man wearing a neck brace stood at the intersection of Mt. Vernon and South Broadway. He appeared to be waiting for a ride and held at least three prescription forms in his hand. Other Atlas patrons approached and spoke with him prior to entering or upon exiting the building. While waiting, this individual moved slowly and gave the appearance of someone possibly suffering a physical ailment. Upon seeing his ride approach, he crossed the street quickly with an improved stride and posture.

- A man holding prescription forms left the area in a Toyota Avalon. A background check on the vehicle's registered owner turned up a criminal record, including arrests for selling controlled dangerous substances, possession of certain prescription drugs and possession of hypodermic needles and drug paraphernalia.
- Although most patients entered and exited Atlas within 20-30 minutes, some individuals entered and exited the office in less than ten minutes holding plainly visible prescription forms. One person entered and exited within the space of less than three minutes while two others did the same in approximately six minutes. Other subjects loitered around the premises or sat in parked cars for up to an hour before re-entering Atlas to obtain prescriptions.
- Many of the subjects that came to Atlas during the surveillance displayed familiarity with each other as evidenced by greetings and conversation.

Questioned under oath about his pain-management credentials, his professional background, his patient consultation and treatment protocols and the amounts of pain medication he has prescribed, Zeid refused to answer substantively. He repeatedly cited his constitutional right of protection against possible self-incrimination. For example:

Q. During the Commission's investigation, we analyzed your prescriptions, and what we did was we selected a pharmacy near the office, are you familiar with Bell Pharmacy?

A. I'm exercising my Fifth Amendment privilege against self-incrimination.

Q. And . . . we subpoenaed all of your prescriptions for Schedule 2 Narcotics from January 2010 to July 21, 2011, and did you know that that was 3,120 prescriptions, sir?

A. I'm exercising my Fifth Amendment privilege against self-incrimination.

Q. Did you know that 99.7% of those prescriptions were for Oxycodone?

A. I'm exercising my Fifth Amendment privilege against self-incrimination.

Q. Did you know, sir, that was over 360,000 pain pills?

A. I'm exercising my Fifth Amendment privilege against self incrimination.

Q. The street value of that many pain pills in New Jersey is almost \$10 million, did you know that?

A. I'm exercising my Fifth Amendment privilege against self-incrimination.

Q. Did you honestly think your patients were taking all of those pain medications?

A. I'm exercising my Fifth Amendment privilege against self-incrimination.

Q. That if you converted your prescriptions into kilograms of Oxycodone, you prescribed almost ten k[ilos] worth of Oxycodone, sir?

A. I'm exercising my Fifth Amendment privilege against self-incrimination.

Mafia Rx

Early in 2012, police in Fort Lee, Bergen County, arrested a physician and his employer on charges of running a pill mill in the shadow of the George Washington Bridge. The arrests of Dr. Kamil Mustafa and Joseph Gianetti, owner and operator of Bridgeview Medical Center, capped a five-month local narcotics investigation that revealed a prescription-for-cash scheme involving the distribution of a veritable alphabet soup of pain medications, sedatives, muscle relaxants and other narcotics. But that was only part of the story. Commission investigators, pursuing a broader line of inquiry, discovered a disturbing twist: In addition to selling access to prodigious amounts of addictive drugs, Gianetti was on the hook for tens of thousands of dollars in loans from members and associates of the Genovese organized crime family.

Gianetti started profiting from health-care in the 1990s when, as a New Jersey-licensed chiropractor, he opened a treatment center – Bridgeview Chiropractic – in Fort Lee. To broaden the business, he hired physicians, paying them an hourly rate to perform medical services that he was neither qualified nor authorized to provide himself. As to the center's administrative operations, Gianetti retained full control. In particular, he handled all billing matters, which was critical to his ultimate business model: submitting false insurance claims to generate revenue to pay off loan sharks.

Gianetti relied on illicit creditors to support a lifestyle that included high-priced cars and gambling. Commission investigators found that in the mid-90s, squeezed by cash-flow problems, he began borrowing heavily from underworld sources, including Joseph DeSimone, a Genovese crime family associate who ran a loan-sharking, gambling and marijuana distribution “crew” from a gas station in Englewood Cliffs.⁹ Gianetti borrowed nearly \$100,000 from DeSimone, paying him back in 1997 with proceeds from the sale of a Lamborghini sports car. Around the same time, Gianetti began accepting substantial loans from a freelance loan shark named Frank Giampa, who brokered money from various mob families.¹⁰ When Giampa pressured him over late payments, Gianetti appealed to his Genovese contacts, including Louis Ruggiero, a Genovese member who arranged for a separate loan to Gianetti while two Genovese enforcers, Stefano Mazzola and another individual, visited Giampa to request that he ease up on his collection schedule.¹¹ By 2003, Gianetti owed \$250,000 to various loan sharks and was paying them \$6,000 weekly. To raise money, he started bilking health insurance companies. His standard method was to submit bogus medical claims bearing unauthorized confidential identification information linked to the physicians he employed at Bridgeview Chiropractic. He also diverted funds to himself and others by forging the doctors’ signatures on insurance reimbursement checks. In 2003, after becoming the target of a federal fraud

⁹ The brother of Ralph DeSimone, also a Genovese associate, who was found shot to death in the trunk of a car at LaGuardia Airport in New York on June 13, 1991.

¹⁰ Giampa was convicted on federal loan sharking charges in the 1980s, but the conviction was reversed on appeal. In 1987, he was subpoenaed to testify in connection with an SCI inquiry into subversion by organized crime and other unscrupulous elements of the check-cashing industry. Under questioning in that inquiry, Giampa repeatedly invoked his Fifth Amendment privilege against self-incrimination.

¹¹ Ruggiero, a member of the Genovese LCN organization, loaned money to Gianetti at usurious interest rates and was later convicted of extortion, serving two years in a federal prison hospital in North Carolina. Mazzola is a Genovese associate known to be extremely violent. He was arrested in 1996 with a Genovese soldier for their involvement in medical fraud, loan sharking, gambling and labor racketeering. Mazzola was arrested again in February 2013 on federal extortion charges. Over the years, he has been incarcerated in both federal and state prisons.

investigation, Gianetti admitted to filing false claims and collecting nearly \$700,000 from four insurance companies. He was sentenced to four months in prison and five months of home confinement with electronic monitoring. He also surrendered his New Jersey chiropractic license. Neither consequence, however, served as a deterrent.

In 2011, Gianetti returned to Fort Lee and established another health-care practice in a Main Street storefront. This new “Bridgeview” facility, however, was a “medical center” in name only. Its ownership was placed in the name of Dr. Kamil Mustafa, but Mustafa’s actual role was to be an employee hired to serve as a conduit for generating cash via the sale of narcotic prescriptions for upwards of \$300 or more apiece.

A graduate of King Edward Medical College in Pakistan, Mustafa received a medical license in New Jersey in 1971. When recruited by Gianetti, his license under rules established by the State Board of Medical Examiners was categorized as “retired-paid.” That designation, applicable to practitioners over age 65, allows them to continue in the profession but forbids them admitting privileges to a hospital or affiliation with any third-party medical group such as an HMO. Patients interviewed by Commission investigators called into question Mustafa’s physical and mental ability to practice, describing him as frail, unkempt and distracted. “He was propped up in a [folding] chair and never moved, with a portable heater directed at him,” recalled one person. Several others said he never left his seat in the examination room. Another said she was “not sure if Mustafa was aware of what was going on around him.”

Despite his condition, Bridgeview records show that Mustafa saw large numbers of patients. Investigators reviewed more than 100 “daily activity sheets” – documents maintained by the center tracking every patient examined and given prescriptions – for various dates in

2010 and 2011 and found that he saw nearly 3,900 persons during that small sample period. For example, records for April 18, 2011 show that Mustafa met with 77 patients. At that rate, assuming a normal eight-hour workday, he saw one patient every six minutes without lunch or breaks. Further investigation revealed that many Bridgeview patients did not live in the immediate or nearby vicinity of the center. Some drove more than 100 miles one way to get there from locations in Atlantic, Gloucester, Ocean, Somerset and Warren counties. Background checks showed that a substantial number had drug-related criminal records.

One former patient, an admitted pain pill addict, described her experience as a Bridgeview client. In the summer of 2011, after her primary physician would no longer prescribe pain medication, she went to Bridgeview at the suggestion of a friend who advised that when she called for an appointment to say that “Sean” referred her. Once scheduled, a staffer at the center instructed her to bring a Magnetic Resonance Imaging (MRI) report with her on her first visit. Replying that she didn’t have one, the employee told her not to worry because the center would place one on file for her.

After signing in at a front desk where a man later identified to her as Gianetti was seated, she was escorted into a room to see Mustafa. The examination consisted of providing a urine sample after which the doctor took her pulse and asked her to bend forward. He then wrote her a prescription for 120 Oxycodone tablets while a female assistant looked over his shoulder. The patient said it appeared that Mustafa was copying information from a previously written script. On some of her visits, the patient said, the assistant tore up the prescription after checking it and asked Mustafa to rewrite and sign it. She said the doctor would sometimes mumble when he spoke, and the assistant would have to interpret for her. The

former patient told investigators that she could only obtain pain medications or mood-altering drugs such as Xanax from Bridgeview because Mustafa would not prescribe other substances, such as the medically-necessary blood pressure medication she required.

Upon leaving the examination room, the patient would stop at the sign-in desk where Gianetti completed the prescription form by filling in her name and other pertinent information. The charge was \$315, payable in cash only. Sometimes, he would recommend that she have the script filled at a local Fort Lee pharmacy. The Commission subpoenaed records from that pharmacy seeking a summary of Schedule II prescriptions signed by Mustafa between December 2009 and November 2011 and found that nearly 90 percent were for the pain medication Oxycodone HCL at a strength of at least 30 milligrams. Other drugs prescribed under his signature during that period included Alprazolam (generic Xanax), Diazepam (generic Valium), Fentanyl, OxyContin, Seconal, Endocet, Carisoprodol and Amphetamine Salts.¹² To determine the flow of money through Bridgeview, the Commission analyzed the center's bank records and found deposits in excess of \$1 million between February 2008 and November 2011. The Commission also found evidence that Gianetti retained substantial cash collected from patients for his personal use. During the same period, bank records show that nearly \$730,000 in checks and \$277,000 in cash was withdrawn from the Bridgeview business account. Mustafa and Gianetti received checks totaling \$85,700 and \$67,575, respectively. A number of checks

¹² Alprazolam is a benzodiazepine used to treat panic and anxiety disorders. Diazepam is a benzodiazepine used to treat anxiety disorders as well as for short term relief of symptoms of anxiety or used adjunctively to treat skeletal muscle spasms or convulsive disorders. Fentanyl is used to treat chronic pain in opioid-tolerant patients. OxyContin is used to treat chronic pain by slowly releasing the potent opioid Oxycodone. Seconal is a sedative used to treat sleep disorders. Endocet is composed of Oxycodone and acetaminophen and is used for pain relief. Carisoprodol is a sedative used for relief of discomfort associated with acute, painful musculoskeletal conditions. Amphetamine Salts is a stimulant often used to treat Attention-Deficit Hyperactivity Disorder (ADHD).

were also issued to cover Gianetti's personal expenses, including payments to Montclair University on behalf of his children; rental of his personal residence in Norwood, N.J.; utility service; lease payments on automobiles; and medical and dental bills. The Bridgeview account was also used to pay an attorney who represented Gianetti in various criminal matters. Because Mustafa was listed in bank records as the center's sole proprietor, Commission investigators examined checks issued through the Bridgeview account to determine if they bore his actual signature. Pronounced differences were found on checks purportedly signed by him through 2011.

In addition, examination of a bank account in Gianetti's name revealed nine suspect currency transactions totaling \$55,500. Multiple deposits of this currency were conducted in a manner suggestive of "structuring" in which each cash deposit consisted of less than \$10,000, thus placing it below the threshold at which a bank or financial institution must file a federally required Currency Transaction Report (CTR) with the IRS. Structuring is commonly associated with a variety of financial crimes, including fraud and money-laundering.

• • •

Gianetti and Mustafa were arrested in February 2012 on licensing violations and drug-related charges. For his part, Mustafa surrendered his license to practice medicine, but Gianetti was back in business as of June 2012. Commission investigators observed him at that time in the vicinity of Bridgeview's office and, later, through a phone call placed by an agent familiar with his voice, established that he was inside as numerous individuals entered and exited. Many vehicles parked nearby were found to be registered to persons residing considerable distances from Fort Lee.

Referrals and Recommendations

The Commission refers the findings of this investigation to the following agencies of government for whatever action is deemed appropriate:

- Office of the Attorney General of New Jersey
- Office of the United States Attorney for the District of New Jersey
- New Jersey Division of Consumer Affairs
- New Jersey Board of Medical Examiners
- Office of the County Prosecutor in each of New Jersey's 21 counties

• • •

The record of this investigation demonstrates that the challenges posed by drug abuse have taken on disturbing new dimensions that call into question the conventional wisdom regarding gateway drugs and addiction, and the adequacy of current medical oversight and law enforcement strategies. We now live in a State where the abuse of legitimate prescription pills serves increasingly as a route to the unlawful world of heroin, which is cheap, widely available and so pure it can be used without the junkie stigma or mess of needles while producing a high matching or exceeding that of any legitimate pharmaceutical painkiller. This tangled intersection of legal and illicit narcotics constitutes a crisis whose multiple consequences are plain for all to see: the countless deaths and damaged lives, the spiking crime, the subverted recesses of the medical and pharmaceutical professions, the exploitation by gangs and other criminal elements.

The scope and complexity of these issues demand a creative, multi-faceted response by policymakers, legislators, regulators and law enforcement. Those responsible for policing physicians, pharmacists and others in the medical community need to re-examine and strengthen mechanisms to ensure appropriate professional oversight and accountability. Criminal justice authorities need new tools and new statutory authority to address this growing phenomenon. More fundamentally, as noted at the outset of this report, the public conversation about establishing a sensible drug policy needs to be broadened and amplified.

In hopes of spurring that discussion, and pursuant to its statutory mandate, the Commission makes the following recommendations for statutory and regulatory reform:

1. Establish Explicit Prescription Standards for Physicians

Given the central role of physicians in providing legitimate medical care, they should be held to the highest standards of accountability regarding the prescription of Schedule II narcotics for treatment of pain. In particular, the New Jersey State Board of Medical Examiners should adopt and incorporate into its regulatory framework a model policy established by the national nonprofit Federation of State Medical Boards for the prescription and use of controlled substances. The model policy sets forth clear standards for use of drugs in pain management, emphasizes the primary goal of ensuring that suffering patients find relief and balances that objective against the countervailing pressures of laws and regulations designed to protect public health and safety by tightly regulating access to and use of such substances. It provides guidelines for evaluation of patient needs, creation of treatment plans and circumstances requiring consent agreements. It also requires physicians to conduct periodic evaluation of

patient progress, make referrals to other medical practitioners where necessary and maintain complete and accurate medical records on all aspects of pain treatment. Finally, the policy clearly stipulates that all prescriptions written for controlled substances are subject to prevailing state and federal laws, including the terms and requirements of professional licensure.

Although select pieces of the model policy have been adopted here, key elements – including explicit definitions of such terms as “acute pain,” “chronic pain,” “addiction” “tolerance,” and “substance abuse” – are absent from the State’s regulatory architecture. By contrast, other states have adopted the model policy, if not entirely at least substantially, and as a single administrative directive or regulation. Florida, for example, is notable for having actually codified key sections to serve as formal standards of practice for physicians engaged in pain management. New Jersey regulators should look to that state’s actions as a template.

In addition to being held to clearly defined standards, physicians proactively should play an important role in restricting the nonmedical use of controlled pain medications. Unlike states such as neighboring Pennsylvania, the relevant New Jersey regulations do not expressly require the licensed medical community to exercise diligence in the prevention of drug diversion for illegitimate usage. Doctors should recognize themselves – and be recognized – as a fundamental part of the solution to drug abuse, and New Jersey’s regulatory code should make it plain that they are central to that effort.

2. Impose Tougher Penalties for Prescription Drug Diversion

The New Jersey State Board of Medical Examiners is responsible for protecting public health and safety by determining and evaluating the qualifications of applicants for licensure, establishing standards of practice and disciplining those who violate the terms and conditions of their license. Many regulators and law enforcement officials, however, contend that with regard to illicit drug diversion and improper prescribing of pain medication, the Board's actions have generally been weak and infrequent. Data collected by the national Federation of State Medical Boards (FSMB) tends to support this contention. The FSMB annually compiles a list of all disciplinary actions imposed by 70 member medical and osteopathic boards, including New Jersey's State Board of Medical Examiners. For 2011, the organization reported a total of 6,034 such actions, 1,905 of which resulted in loss of license or licensed privilege and 1,323 in some form of restriction of licenses or licensed privilege. According to the FSMB, New Jersey's medical board that year administered 103 disciplinary actions against a total of 97 physicians – in a state with nearly 35,000 licensees.

Furthermore, the disciplinary system currently in place here provides little in the way of meaningful disincentives against illicit prescriptions and pill diversion. Those caught engaging in this activity face a disciplinary process that tends to be lenient; they possess the financial means to easily afford the nominal fines generally imposed; and, if charged criminally for improper prescribing or diversion, the charges typically are downgraded to lesser offenses that do not carry significant jail time, if any at all. Although the Board of Medical Examiners has moved aggressively against physicians in several recent cases, the full record demonstrates that

it must take a more aggressive posture if it is to play a meaningful role against the current prescription drug abuse drug epidemic. Thus, the Commission recommends the following reforms:

Financial Penalties

Laws governing the Board's authority to impose sanctions should be amended to provide for tougher financial penalties against medical licensees who improperly prescribe controlled substances, particularly those practitioners who do so serially.¹³ Currently, the Board may impose a civil penalty of not more than \$10,000 for the first violation and a fine of no more than \$20,000 collectively for a second or subsequent violation. The Commission recommends that violations for unlawful prescribing and distribution by licensees be subject to civil penalties on a per-prescription or per-incident basis and that Board, in each instance, be empowered with the discretion to impose fines of not less than \$10,000 for the first violation and not less than \$20,000 for each subsequent prescription or incident.

Criminal Penalties

In addition to being subject to enhanced civil sanctions at the Board level, physicians convicted in court of improperly distributing controlled substances should face significant criminal penalties. Under New Jersey's Criminal Code, the unlawful dispensation or distribution of Oxycodone currently constitutes, at maximum, an offense of the second degree, but even that is illusory. The practical reality is that most such cases are adjudicated as lesser third-degree offenses with the likelihood of little or no significant jail time, according to experts who

¹³ Legislation was introduced recently to increase the penalties imposed by the Board for improper prescribing. See S-2833 (Sarlo) and A-4216 (Eustace).

testified before the Commission. By contrast, a physician-defendant prosecuted and convicted federally for such activity faces incarceration of a decade or more under mandatory federal sentencing guidelines. Enhanced penalties for a violation of New Jersey criminal law could deter many would-be violators from crossing the line. Thus, the Commission recommends that any crime relating to the unlawful distribution of Oxycodone or any other drug classified as a Schedule I or Schedule II narcotic, be boosted one degree level, making the highest possible offense a first-degree crime and increasing the likelihood of a jail sentence for offenders.

3. Create a Statewide Opioid Strike Force

The prescription pain pill and heroin problems are growing in rural and suburban areas within the state where law enforcement resources are typically limited. The Commission also found that pain pill addicts often drive significant distances to obtain diverted drugs, so one bad doctor may be facilitating the illicit distribution and consumption of pain medication in a large geographical area through multiple law enforcement agency jurisdictions. Lastly, large-scale pill diversion cases are inherently complex and require a myriad of investigative disciplines and resources. Thus, the very dynamics of large-scale diversion cases lend themselves to investigation and prosecution by multi-agency task forces.

Given the urgency of New Jersey's prescription painkiller crisis, the State should establish a Strike Force devoted solely to identifying, investigating and prosecuting the illegal sources and distribution of prescription pills. Operational staff should include state, federal and local law enforcement personnel with experience in this arena, working in conjunction with agencies that oversee, regulate and/or investigate illicit sources of pill diversion. In addition to

taking the lead in investigating prescription pill abuse, the Strike Force would provide training for law enforcement officials, physicians, pharmacists and other health-care professionals in state-of-the-art methods to detect drug diversion techniques and related abuses.

4. Establish Oversight of Medical Practice Ownership and Management

A major problem identified by the Commission in this investigation involves illicit business relationships between practicing physicians and unlicensed individuals who are not doctors. Under such a relationship, the physician serves merely as a figurehead in a corporate structure arranged in such a way as to hide the true owner. Unlicensed former doctors and unscrupulous individuals with links to organized crime were found to be profiting from these illicit medical practices. To curtail this activity, the New Jersey Division of Consumer Affairs (DCA), during the process in which a physician applies for license renewal, should have the express authority to gather information about any significant business relationship involving his/her medical practice.

The Commission recommends the Legislature grant DCA the power to obtain information about all parties that conduct business on the premises of a medical practice, or in connection with a doctor providing medical services in New Jersey. Further, the Legislature should provide a statement of intent to serve as a framework for promulgating regulations to execute this important administrative oversight. Appropriate rules could then be adopted, including but not limited to:

- Registration of non-medical personnel employed by the practice;

- Disclosure of all non-medical business associations, including any and all management companies; and
- Disclosure of any financial relationships with non-medical-licensees

These requirements would serve as a reasonable means of gathering relevant information about individuals and entities connected to a medical practice in an effort to root out bad actors, while placing a minimal burden on legitimate practitioners.

5. Enhance New Jersey's Prescription Monitoring Program

Implemented in 2012 and administered by the Division of Consumer Affairs as part of a national effort to combat prescription pill abuse, New Jersey's Prescription Monitoring Program (PMP) collects and analyzes statewide data on controlled dangerous substances and human growth hormones dispensed by pharmacies. While licensed medical professionals, DCA administrators and law enforcement officers may obtain information from the database under certain circumstances, current access is so tightly restricted that it has had the effect of diminishing the PMP as a proactive law enforcement investigative tool.

Widen Law Enforcement Access to PMP Prescription Information

The PMP would be positioned as a more effective weapon against New Jersey's pain-pill epidemic if law enforcement were granted greater access to the information and data gathered and maintained by it. Under current rules, stringent restrictions aimed at protecting patient privacy preclude law enforcement agencies here from gaining direct access to PMP prescription information except pursuant to an explicit DCA referral or through court order or subpoena, and then only when conducting a specifically targeted investigation. New Jersey should join

other states, such as Florida, Massachusetts, Ohio and Connecticut that already have established a better balance between patient confidentiality and the practical exigencies of meaningful law enforcement. Thus, the Commission recommends that the Legislature amend the current PMP enabling statute to provide *bona fide* law enforcement personnel engaged in active investigative work with a more reasonable level of Web-based access as long as they comply with enhanced security protocols. In essence, under such a revised access regimen, PMP information and data would be treated like highly sensitive criminal justice system information requiring special access safeguards and control procedures, including but not limited to the following:

- Clearly defined rules of conduct for viewing, disseminating and destroying information obtained from the PMP
- Official documentation signed by the using agency agreeing to all security requirements and the designation of an assigned Agency Coordinator to serve as point of contact on matters involving all PMP access requests
- A case number and description for each PMP information request, with all inquiries subject to tracking and the receiving party clearly identified
- Periodic audits by each receiving agency to ensure compliance
- Clearly delineated penalties for improper use of the system, including legal and/or administrative action. Violators would be subject to termination of employment and possible criminal charges.

Require Use of the PMP by Physicians

New Jersey is one of a handful of states that do not require medical practitioners who prescribe drugs to register with the PMP or to access the data and information maintained by it. Steps should be taken to reverse that. At a minimum, all practitioners who are among the top

30 percent of all controlled-substance prescribers in the State within the preceding 12-month period should be required to register for PMP access. Once registered, prescribers themselves or their professionally licensed designee should also be required to query the PMP to determine where and when their patients filled prior prescriptions, the type and quantity of drugs patients received and the identity of the prescribing physician. Prior to writing any prescription for controlled substances, physicians should also be required to conduct a targeted review of patients' medical histories for patterns suggesting drug abuse.

Require Daily Data Input by Pharmacy Personnel

New Jersey should adopt legislation requiring pharmacists to upload all relevant prescription information to the PMP by the end of each business day versus the current requirement of at least once every 15 days. Concomitant legislation would enable DCA to update and modernize the PMP system to handle such daily updates.

6. Impose Stronger Control of Prescription Forms

There are nearly 50 manufacturers in New Jersey that make specialized paper used in the production of blank official prescription forms – a number that suggests widespread vulnerability to security lapses and the consequent delivery of such forms into the wrong hands. Even if unscrupulous individuals fail to obtain blanks, they can easily manipulate used prescriptions forms with readily available computer technology that enables them to erase any writing and reprint the altered and newly blank form hundreds of times. Thus, the Commission

recommends implementation of stronger requirements for embedded security markers, such as watermarks and barcodes, or the designation of a single source of such paper.¹⁴

7. Heroin: Enact Sensible Criminal Sanctions

Heroin is cheap, pure and readily available, and many of today's opioid pill abusers are becoming tomorrow's heroin junkies. Given advances in technology and growth in affluent suburban demand, a bag of heroin now is only a text message or cell phone call away. Using vehicles with drugs stashed in hidden on-board "traps," dealers deliver product to customers waiting in suburban strip malls or shopping center parking lots. Furthermore, given its relative purity, the heroin available in New Jersey does not have to be injected; it can be snorted to produce the desired high, making it easier to introduce to new users. And, as purity and availability have increased, prices have plummeted to the point where heroin frequently becomes the drug of choice over more costly prescription painkillers of lesser effect.

To assist law enforcement in combating heroin trafficking, the Commission recommends the Legislature equip the State's Criminal Code with a lower and more realistic legal threshold for grading charges of criminalized possession of heroin with intent to distribute.¹⁵ The current threshold – identical to that for cocaine – ignores the practical differences between how those two drugs are dealt and used. In reality, the amounts of heroin consumed by an average user

¹⁴ The Division of Consumer Affairs recently proposed regulations to increase security measures on prescription blanks.

¹⁵ Legislation was introduced recently in the Senate and Assembly, S-2781 (Connors, Van Drew) and A-4151 (Albano, Andrzejczak, Gove, Rumana and Rumpf), that would require drug-dealing offenses to be graded by "units" rather than weight of controlled dangerous substances, including heroin. According to the legislation, allowing prosecutors to rate the seriousness of a drug distribution offense based upon units rather than the weight of drugs seized by law enforcement would, in many instances, allow for a defendant to be charged with a higher degree offense than currently permitted by law. The charge by units would apply only to persons accused of distributing, or possessing illicit drugs with intent to distribute.

and carried by an average dealer at any given time are far lower than those involving cocaine. Thus, individuals arrested for heroin offenses often are able to avoid the most serious possession charges. By way of illustration, the average retail “unit” of heroin consumption is one bag that contains approximately one one-hundreth (.01) to two one-hundreths (.02) of a gram of heroin. Dealers typically package it as “bricks” of approximately 50 bags each, and users often purchase the heroin as a brick. A second-degree offense requires possession of at least a half-ounce of heroin, which equates to between 500 and 1,500 individual bags – approximately \$3,000 worth of the drug. To trigger a first-degree offense, the most serious, the threshold number could be as much as 7,100 individual bags of heroin worth almost \$30,000. According to law enforcement authorities, even the biggest regional drug kingpins are moving only 50 bricks of heroin a week – at most, a second-degree offense. Thus, enterprising drug dealers are wise enough to carry only a few bricks at any given time, assuring that, if arrested, they would probably face no more than a minor third-degree offense upon arrest and, if convicted, no more than two years in prison.

To address this disparity, the Commission recommends a proportioned decrease in the various heroin-offense thresholds. The threshold for a first-degree offense should be lowered from five ounces (141 grams) to 2.5 ounces (70 grams) and the second-degree threshold from a half-ounce (14 grams) to .17 of an ounce (five grams). Any amount less than .17 of an ounce should be a third-degree offense.

8. Criminalize Use and Installation of Vehicle “Traps”

Use of hidden “traps” in motor vehicles is a major problem for law enforcement. These hidden compartments, some armored and equipped with sophisticated triggering mechanisms to open and close them, allow drug traffickers to conceal quantities of drugs and money in ways that can be difficult even for trained dogs to detect. Thus, the Commission recommends criminalizing the intentional manufacture, possession and installation of motor vehicle traps that promote the drug trade. In addition, any person who publishes plans or instructions for the manufacture of such mechanisms should be held criminally liable as well.

9. Establish Stronger Regulation of Pre-Paid Cell Phones

Pre-paid cellular devices pose a serious threat in New Jersey because they comprise one of the primary tools of the illicit drug trade. These phones may be purchased without a contract and do not require the purchaser to provide valid identification. Their low cost and anonymity provide criminals with a systemic advantage over law enforcement’s efforts to determine owner identities and to lawfully monitor potentially criminal communications. Therefore, the Commission recommends reforms in the following areas:

- Legislation should be enacted prohibiting any cell phones sold in New Jersey from being activated by a service provider without verifiable subscriber information, including but not limited to the name of the subscriber, address, date of birth, number of phones being activated, serial number and phone number assigned.

- Cellular phone companies doing business in New Jersey should be required to retain certain forms of user information and communications (e.g. text messages) for an extended period of time. In many instances, the records that these private companies retain may be the only evidence available to establish that a crime may have occurred.
- Smartphone applications (“apps”) enable users to place virtually undetectable domestic and international calls to regular phone numbers using the phone's Wi-Fi or mobile broadband connection. Other apps enable users to select a phone number from virtually any area code in the country, and change that number once for free. Federal law enforcement agencies have recently sought legislation to require online communications technologies, including peer-to-peer, social networking and smart phone apps, to have a “backdoor” making them accessible for government wiretaps. The Commission supports a viable federal solution that will give New Jersey’s law enforcement community lawful access to this growing area of untraceable communication.

10. Change the GPS Warrant Requirement

Law enforcement officials told the Commission that drug dealers are impeding investigations by using rental vehicles as a means to evade efforts to track them. Under current legal rules, investigators seeking to use a Global Positioning System (GPS) device to follow a suspected trafficker’s movements must obtain a warrant based on sufficient evidence involving

the use of a particular vehicle – a requirement often stymied by the rapid rotation of rental vehicles. As an alternative, New Jersey should consider adopting a process that would enable law enforcement, under circumstances where the target is using rental vehicles in furtherance of illicit activity, to obtain an anticipatory “roving GPS placement” warrant that attaches to a specific individual instead of a particular vehicle.

APPENDIX

N.J.S.A. 52:9M-12.2 provides that:

- a. The Commission shall make a good faith effort to notify any person whose conduct it intends to criticize in a proposed report.*
- b. The notice required under subsection a. of this section shall describe the general nature and the context of the criticism, but need not include any portion of the proposed report or any testimony or evidence upon which the report is based.*
- c. Any person receiving notice under subsection a. of this section shall have 15 days to submit a response, signed by that person under oath or affirmation. Thereafter the Commission shall consider the response and shall include the response in the report together with any relevant evidence submitted by that person; except that the Commission may redact from the response any discussion or reference to a person who has not received notice under subsection a. of this section.*
- d. Nothing in this section shall be construed to prevent the Commission from granting such further rights and privileges, as it may determine, to any person whose conduct it intends to criticize in a proposed report.*
- e. Notwithstanding the provisions of R.S. 1:1-2, nothing in this section shall be deemed to apply to any entity other than a natural person.*

The following material was submitted pursuant to those statutory requirements.



*CERTIFIED BY THE
SUPREME COURT OF NEW JERSEY
AS A CIVIL TRIAL ATTORNEY

CHARLES H. NUGENT, JR.*
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July 2, 2013

By Fax – 609-633-7366
and 1st Class Mail

Chad W. Lackey, Esquire
State of NJ – Commission of Investigation
28 West State Street
PO Box 045
Trenton, NJ 08625-0034

RE: **Randy Zeid, DO**
Dissemination No. 13-06-001
Our File No. 7260

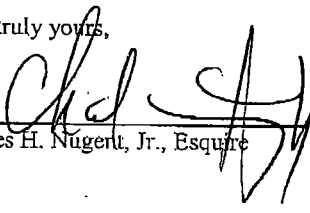
Dear Mr. Lackey:

I represent Dr. Randy Zeid.

Enclosed please find a letter from Dr. Zeid dated July 2, 2013, responding to the proposed Commission report. We understand that the Commission will include Dr. Zeid's written response in its report.

Once the report, with Dr. Zeid's response, has been issued and disseminated, would you please provide a copy of same to me.

Very truly yours,


Charles H. Nugent, Jr., Esquire

CHN:aba
enclosure
cc: Randy Zeid, DO

7260\Zeid\SCI Lackey.ltr

07/02/2013 10:10:02 FAX 000000 0110 CHARLES H. RUGENT JR. ESQ. 0003/004

July 2, 2013

Chadd W. Lackey, Esquire
Commission of Investigation
28 W. State Street
PO Box 045
Trenton, NJ 08625

Re: Randy Zeld, DO

Dear Mr. Lackey:

Please consider this letter as a written response to the SCI report which you intend to publish concerning the SCI investigation, and as outlined in your letter of June 19, 2013.

First, much of the SCI report consists of exaggerated, unverified allegations intended to sensationalize and alarm, but which is short on facts which prove that anything wrong happened. I did not violate any statute, code, or rule as it pertains to evaluating and examining patients, or providing prescriptions based upon medical need. My treatment of patients was within the standard of care of the medical profession, and the SCI "investigation" doesn't prove otherwise.

Second, the New Jersey Administrative Code, 13:35-7.1A, prohibits a physician from dispensing drugs or issuing prescriptions without first having conducted an examination consisting of a history and physical examination, diagnosis, therapy plan, etc., all of which must be documented in the patient's file, and was for each of my patients. There are limited exceptions. I complied in every respect with the requirements of the law.

Third, all of my patients signed a pain medication contract, and were subject to random urine drug screens to ensure that patients were not using or abusing other drugs. If a patient abused prescriptions, or failed to follow physician orders or direction, the patient was discharged from the practice. Over 200 patients were discharged from the practice due to non compliance with their medication contract.

Fourth, neither I nor my counsel has had an opportunity to evaluate any investigative reports, statements of witnesses, the credibility of unnamed witnesses, or whether the allegations are in fact true. For example, no physician is ever able to control what a patient does with a prescription after they leave the office, or who they give or sell a pill to after filling a prescription. So, for the "man wearing a neck brace", or the man who snorted crushed pills, or the government employee who lost his job, I have no control over what they do, whether they abuse prescription or non-prescription medications, or commit crimes anymore than the SCI does. If I suspect a patient of abusing prescriptions, I immediately take steps to terminate the patient physician relationship.

Fifth, your report indicates that over a 19 month period in 2010 and 2011, I wrote 3100 prescriptions filled at a local pharmacy. You provided me no proof of those numbers, but even if that was the case, considering the number of patients I saw, that many of them were there to treat pain, that the same patients came back every 30 days or less (which means one patient could have received 19 or more prescriptions over that period of time), that the law authorizes physicians to issue multiple prescriptions to one patient, and that patients were issued prescriptions for short and long term pain, including intractable pain, the number of prescriptions the report alleges is not unreasonable.

Sixth, NJSA 45:9-22.19, authorizes physicians to issue prescriptions for Schedule II controlled substances to current patients without an examination, which may account for the report allegation that some patients entered and exited the office within ten minutes.


Seventh, on Tuesdays, it could "get a little crazy", since there could be 3-4 physicians practicing from the office, which would account for the number of patients around the office. On other days, when only one physician was working, there would not be the same number of patients.

Eighth, the office is no longer open, and has been closed since the end of April 2013.

Ninth, I took the fifth amendment on the advice of counsel, I was subpoenaed to be there, I was not given an opportunity to review any documents, and I did not wish to participate in a debate with you over an investigation whose conclusion was predetermined.

I certify that the following statements are true to the best of my knowledge and belief, and if any of the foregoing statements are willfully false, I am subject to punishment.

Respectfully,



Randy Zeld, DO



State of New Jersey
Commission of Investigation
609-292-6767
www.state.nj.us/sci